Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Sep 20, 2016;	2016_507628_0016 (A1)	022127-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE LADY MINTO HOSPITAL AT COCHRANE
241 EIGHTH STREET P.O. BOX 4000 COCHRANE ON P0L 1C0

Long-Term Care Home/Foyer de soins de longue durée

VILLA MINTO
241 EIGHTH STREET P.O. BOX 280 COCHRANE ON P0L 1C0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MARIE LAFRAMBOISE (628) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Amendment required to capture all findings from the Inspection Report related to s.19 in Compliance Order #002 of the Order(s) report.

Issued on this 20 day of September 2016 (A1)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MARIE LAFRAMBOISE (628) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 9, 2016 to August 12, 2016 and from August 15, 2016 to August 18, 2016.

This inspection included an intake regarding a critical incident the home submitted related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Previous DOC, Maintenance Program Lead, Activity and Volunteer Coordinator, Infection Control Nurse, Restorative Care Coordinator, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents' family members and residents.

The Inspector(s) conducted an inspection of common areas, observed the provision of care to residents, observed staff to resident interactions, reviewed various policies and procedures and reviewed clinical records, critical incident reports and employee personnel file records.

The following Inspection Protocols were used during this inspection:

Dining Observation

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Skin and Wound Care

Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **9 WN(s)**
- **4 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and their bed system was evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

Inspector #627 observed resident #001 on August 10, 2016, to have two top rails engaged in the guard position during stage one of the inspection.

Inspector #627 completed a review of the Minimum Data Set (MDS) assessment upon admission which documented that resident #001 used bed rails for bed mobility or transfer.

A review of the care plan by Inspector #627 documented the use of restraints as a focus that required resident #001 to have two quarter rails on bed used as a PASD (Personal Assistance Services Device).

During an interview with Inspector #627, RN #102 stated that if the resident was admitted from another facility, and the facility had used bed rails, then the bed rails were continued to be used. As well, it depended on resident and family's preference. RN #102 further stated that when bed rails are used the resident is not assessed for the use of bed rails.

During an interview with Inspector #612, the Program Lead for Maintenance and

Electrician #103 stated they confirmed that they did not assess residents for bed rail usage, they only assessed the bed system. [s. 15. (1) (a)]

2. Resident #005 and #006 triggered from stage one of the Resident Quality Inspection (RQI) related to bed rail use. On August 9, 2016, Inspector #612 observed that resident #005 and Inspector #627 observed that resident #006 both utilized two quarter rails, engaged in the guard position while in bed.

On August 16, 2016, Inspector #627 interviewed DOC #100 who stated they were not aware of any specific resident assessment when bed rails were used. DOC #100 reported that they further verified with the previous DOC (DOC #105), via telephone and the previous DOC (DOC #105), stated that there was currently no specific resident assessment completed regarding the resident when bed rails were in use.

A memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August 12, 2012 was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes.

This document references the 'Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings' (CGA), as a prevailing practice for the assessing the use of bed rails. The CGA document indicated that automatic use of bed rails may pose unwarranted hazards to resident safety and evaluation is needed to assess the relative risk of using the bed rail compared with not using it for an individual patient.

The use of bed rails should be based on a resident's assessed needs, documented clearly and approved by the interdisciplinary team. Policy considerations included but were not limited to a risk-benefit assessment that identified why other care interventions were not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the resident should be included in the residents' plan of care.

Additionally, a comprehensive assessment and identification of the residents' needs which include comparing the potential for injury or death associated with use or no use of bed rails to the benefits for an individual resident should be included.

The CGA identified procedures including individualized resident assessments, sleeping environment assessments, and care planning guidelines. As well, Health Canada recommended that residents be re-assessed for risk of entrapment whenever there is a change in the resident's medication or physical condition. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse and free of neglect by the licensee or staff in the home.

Inspector #627 reviewed a Critical Incident (CI) report that was submitted by the home to the Director on a specific day in 2016, related to an alleged staff to resident abuse. The CI report alleged that PSW #106 caused pain when they provided care to resident #006.

During a resident interview in stage one of the RQI, resident #006 stated that they had been treated roughly by PSW #106 while receiving care on two separate occasions. Resident #006 could not recall the dates.

During a further interview with Inspector #627, resident #006 stated that on two separate occasions PSW #106 had provided care in a rough manner; this had caused them to have pain for a certain number of weeks. The PSW no longer provided care for the resident unless another staff member was present.

The LTCHA Ontario Regulation 79/10 defines "physical abuse" as the use of physical force by anyone other than a resident that causes physical injury or pain.

A review of the home's investigation notes revealed that the home determined that PSW #106 caused pain to resident #006. As a result of the home's investigation PSW #106 was disciplined.

A review of the progress notes in resident #006's electronic chart revealed that RPN #111 had made the previous DOC (DOC #105), aware of the incident via email on a certain day, and that the previous DOC (DOC #105), became aware of the incident the next day but did not report this to the Director until three days after the incident.

A review of the policy titled "Zero Tolerance and Abuse and Neglect #LTC-630, Section F- Dealing with Persons who have abused/neglected or alleged to have abused/neglected", last revised in December 16, 2015, required staff/team member (s) to be immediately suspended pending the results of the investigation.

A review of the "Long Term Care Payroll Sign In Sheet" for a particular day, recorded that PSW #106 worked a certain shift.

A review of the Point of Care Audit, for resident #006, on that particular day, indicated that PSW #106 charted that they provided a wide range of assistance to the resident related to activities of daily living.

The Inspector requested and reviewed the dates that PSW #106 was on paid leave pending the CI investigation.

During an interview with the Inspector, DOC #100 stated that it was the home's policy to suspend with pay, all employees accused of abuse pending the results of the investigation. DOC #100 confirmed that PSW #106 had worked and had provided care to resident #006 on a particular day, during the time of the investigation.

2. A review of PSW #106's personnel file by Inspector #627 revealed a letter dated in a specific month in 2016, sent to PSW #106 by the previous DOC, (DOC #105), which stated that the PSW was reported by a co worker to have been rough when they provided care to resident #006 when they were admitted. The previous DOC, (DOC #105), documented in the letter that they cautioned the PSW that there was a fine line between being rough with residents and physical abuse.

DOC #100 provided the Inspector with an email sent to them from the previous DOC, (DOC #105) dated August 12, 2016, which documented that the initial incident was investigated immediately and it was determined the outcome was not abuse and no CIS report was sent to the Director. The previous DOC, (DOC #105), noted that since it happened again, in a particular month, the CIS was completed at that time and PSW #106 received disciplinary action.

During an interview with the Inspector, DOC #100 confirmed that the incident that was reported in a specific month, was not reported to the Director.

3. Inspector #627 conducted a record review for resident #006's records to identify any additional incidents of reported concerns between the resident and PSW #106. Inspector #627 interviewed RPN #112 by telephone who stated that on a specific day in 2015, they had been told by resident #006's substitute decision maker (SDM) that the resident reported to them that PSW #106 was rough giving care. Also, PSW #106 refused at times to assist the resident with a particular activity of daily living as per the plan of care and would not let the resident do their activities of daily living for themselves, as this took too much time and PSW #106 had removed an item from the resident's room which the resident wanted to keep.

The Inspector reviewed an email provided by RPN #112 which the RPN sent to the previous DOC, (DOC #105), on that specific day in 2015. The email documented that both resident #006 and the resident's SDM voiced concerns about PSW #106's interaction with resident #006 and that the resident was upset because PSW #106 took a specific item away. The email also documented that resident #006's SDM stated that resident #006 was scared to ask for anything because they were made to feel a certain way. As well, when PSW #106 attempted to assist the resident with a particular activity of daily living, the resident felt afraid of a particular outcome.

A review of resident's #006's progress notes dated four days after the specific day

in 2015, detailed the conversation the previous DOC, (DOC #105), had with resident #006's SDM. The progress note was regarding the incident on the specific day in 2015.

On August 18, 2016, during a telephone interview with the Inspector, the previous DOC, (DOC #105), stated that they had investigated the incident that occurred on a specific day in 2015 and documented in Point Click Care (PCC). The previous DOC, (DOC #105), confirmed that the incident had not been reported to the Director. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of a resident was complied with.

A Critical Incident (CI) report was submitted to the Director on a specific day in 2016. Inspector #627 reviewed the CI which alleged staff to resident abuse. A review of the CI alleged that PSW #106 had been rough while providing care to resident #006. The resident had experienced pain when the PSW had assisted the resident with an activity of daily living.

A review of the progress notes in resident #006's electronic chart revealed that RPN #111 had made the previous DOC (DOC #105), aware of the incident via email on a certain day, and that the previous DOC (DOC #105), became aware of the incident the next day but did not report this to the Director until three days after the incident.

A review of the policy titled "Zero Tolerance of Abuse and Neglect #LTC-630, Section F- Dealing with Persons who have abused/neglected or alleged to have abused/neglected", last revised December 16, 2015, required staff/team member (s) to be immediately suspended pending the results of the investigation.

A review of the "Long Term Care Payroll Sign In Sheet" for a particular day, recorded that PSW #106 worked a certain shift.

A review of the Point of Care Audit, for resident #006, on that particular day, indicated that PSW #106 charted that they provided a wide range of assistance to the resident related to activities of daily living.

The Inspector requested and reviewed the dates that PSW #106 was on paid leave pending the CI investigation.

During an interview with the Inspector, DOC #100 stated that it was the home's policy to suspend with pay all employees accused of abuse pending the results of the investigation. DOC #100 confirmed that PSW #106 had worked and provided care to resident #006 on that particular day, during the time of investigation and should not have. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is in place, and that the immediate suspension of staff of any suspected abuse of a resident, pending the results of the investigation, is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse had occurred or may occur, immediately report the suspicion

and the information upon which it was based to the Director.

A Critical Incident (CI) report submitted to the Director on a specific day in 2016, alleged that PSW #106 had been rough while providing care to resident #006 three days prior to the submitted report.

A review of the home's investigation notes revealed that the home determined that PSW #106 caused pain to resident #006. As a result of the home's investigation PSW #106 was disciplined.

A review of the progress notes in resident #006's electronic chart revealed that RPN #111 had emailed the previous DOC (DOC #105), on a certain day, and that the previous DOC (DOC #105), became aware of the incident the next day.

During an interview with the Inspector, DOC #100 stated that all abuse or suspected abuse were to be reported immediately to the Director. DOC #100 confirmed that the alleged incidence had not been reported immediately to the Director and should have been.

2. A review of PSW #106's personnel file by Inspector #627 revealed a letter dated in a specific month in 2016, sent to PSW #106 by the previous DOC, (DOC #105), which stated that the PSW was reported by a co worker to have been rough when they provided care to resident #006 when they were admitted. The previous DOC, (DOC #105), documented in the letter that they cautioned the PSW that there was a fine line between being rough with residents and physical abuse.

DOC #100 provided the Inspector with an email sent to them from the previous DOC, (DOC #105), dated August 12, 2016, which documented that the initial incident was investigated immediately and that the previous DOC, (DOC #105), determined the outcome was not abuse and no CIS report was sent to the Director.

During an interview with the Inspector, DOC #100 confirmed that the initial incident was not reported to the Director.

3. During a telephone interview with the Inspector, on August 17, 2016, RPN #112 stated that on a specific day in 2015, they had been told by resident #006's substitute decision maker (SDM) that the resident said that PSW #106 was rough giving care. Also, PSW #106 refused at times to assist the resident with a particular

activity of daily living as per the plan of care and would not let the resident do their activities of daily living for themselves, as this took too much time and PSW #106 had removed an item from the resident's room which the resident wanted to keep.

The Inspector reviewed an email provided by RPN #112 which the RPN sent to the previous DOC, (DOC #105), on that specific day in 2015. The email documented that both resident #006 and the resident's SDM voiced concerns about PSW #106's interaction with resident #006 and that the resident was upset because PSW #106 took a specific item away. The email also documented that resident #006's SDM stated that resident #006 was scared to ask for anything because they were made to feel a certain way. As well, when PSW #106 attempted to assist the resident with a particular activity of daily living, the resident felt afraid of a particular outcome.

On August 18, 2016, during a telephone interview with the Inspector, previous DOC, (DOC #105), stated that they had investigated the incident that occurred on a specific day in 2015 and documented in Point Click Care (PCC). The previous DOC, (DOC #105), confirmed that the incident had not been reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance where a person, who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Inspector #627 conducted an interview with the president of the Resident Council, resident #006, during the RQI. During the interview, resident #006 stated that their concerns were addressed verbally by DOC #100 or by the specific department to which the concern pertained. Resident #006 confirmed they did not have their concerns addressed in writing within 10 days.

During an interview with the Inspector, the Activity and Volunteer Coordinator #104, who is the liaison for the home and Resident Council, stated that all concerns were addressed verbally and not by writing.

During an interview, with Inspector #627, DOC #100 confirmed that all concerns voiced by the family council were addressed verbally and not in writing. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee respond in writing within 10 days of receiving the Residents' Council's advice related to concerns or recommendations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM was immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident or caused distress to the resident that could potentially have been detrimental to the resident's health or well being.

Inspector #627 reviewed a Critical Incident (CI) report submitted to the Director which alleged that on a particular day in 2016, resident #006 reported to RPN #111 that PSW #006 was rough with them when providing care. This had caused the resident pain.

A review of the progress notes in resident #006's electronic chart revealed that RPN #111 had made the previous DOC (DOC #105), aware of the incident via email on the particular day, and that the previous DOC (DOC #105), became aware of the incident the next day. Specific progress notes, revealed that RPN #111 had made the SDM aware of the incident three days after becoming aware of the incident.

The Inspector reviewed the policy titled "Zero Tolerance and Abuse and Neglect #LTC-630", last revised on December 16, 2015, which required that the SDM or the person requested by the resident to be immediately notified of the incident if the resident is harmed, and within 12 hours for all other situations of alleged or witnessed abuse or neglect.

During an interview with the Inspector, RPN #111 stated that following the incident on the particular day, they had returned to work three days later, and noted that the SDM had not been notified and proceeded to call them.

During an interview with the Inspector, DOC #100 confirmed that the resident's SDM was only made aware of the incident three days after the incident and should have been notified immediately. [s. 97. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision maker (SDM) is immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident or caused distress to the resident that could potentially be detrimental to the resident's health or well being, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent and complement each other.

During the course of the RQI, the family member of resident #005 told Inspector #628 that resident #005 was assessed by a specialist and was to receive a prescribed treatment initially but did not receive the treatment until two months later. The resident continued to have certain symptoms during this delay.

On August 16, 2016, Inspector #628 interviewed RN #102 who stated that resident #005 had been seen by a specialist on a particular day. The resident's family

member asked RN #102 one month later, whether the resident was receiving a prescribed medication as ordered by the specialist. The RN told the family member that they were not aware of such a prescription. The family member went to the resident's attending physician's office and picked up a copy of the prescription and brought this to the home's RN. The RN stated they faxed this prescription to the pharmacist on the day they were questioned by resident #006's family, and initialled the document as faxed to pharmacy. RN #102 stated that the pharmacy required the attending physician's order and the RN stated once they faxed the physician the order, they followed up with the resident's attending physician several times by phone. The RN stated that the physician followed up with an order for the medication, for resident #005.

On August 17, 2016, Inspector #628 interviewed DOC #100 who stated that resident #005 had been seen by the specialist on a particular date, and a treatment was ordered. The home did not receive a prescription from the specialist for resident #005. DOC #100 stated that the home's pharmacy told DOC #100 that they did not receive the faxed copy from the home for resident #005, dated as faxed to pharmacy on a specific day. DOC #100 stated that the pharmacy stated they only received the order for medication by the resident's attending physician on certain day, and that there would not have been an issue reading the specialists signature nor with the authorization to process this order.

During a further interview with the DOC, it was stated that the home's staff, the specialist, the attending physician and the pharmacist who were involved in the different aspects of care of resident #005 did not collaborate with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent and complemented each other, and the delay of receiving medication should not have happened. [s. 6. (4) (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendation.

Inspector #627 conducted an interview with a Family Council representative. The Family Council representative stated their concerns were verbally addressed by the management and the Family Council had not received any written responses.

During an interview with the Inspector, the Activity and Volunteer Coordinator #104, who was the liaison for the home and the Family Council, stated that all concerns were addressed verbally.

During an interview, DOC #100 confirmed that all concerns voiced by the Family Council were addressed verbally and should have been addressed in writing. [s. 60. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Resident's Council in developing and carrying out the satisfaction survey, and in acting on its results.

A review of the " LTCH Licensee Confirmation Checklist" provided to DOC #100 during the RQI revealed that DOC #100 had indicated "no" to question nine of the "Continuous Quality Improvement and Satisfaction Survey" as follows:
"9) Does the licensee seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results?"

An interview with the president of the Resident Council, resident #006, was conducted during the RQI by Inspector #627. During the interview, resident #006 stated that the Resident Council was not asked for advice in developing and carrying out the satisfaction survey.

During an interview with the Activity and Volunteer Coordinator #104, who was the liaison for the home and the Resident Council, stated that the Resident Council had not been asked for input in developing and carrying out the survey as the survey was already developed and had not changed for a long time.

Inspector #612 interviewed DOC #100 who confirmed that the survey was developed without the involvement of the Resident Council. [s. 85. (3)]

Issued on this 20 day of September 2016 (A1)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : MARIE LAFRAMBOISE (628) - (A1)

Inspection No. / No de l'inspection : 2016_507628_0016 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 022127-16 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Sep 20, 2016;(A1)

Licensee / Titulaire de permis : THE LADY MINTO HOSPITAL AT COCHRANE
241 EIGHTH STREET, P.O. BOX 4000,
COCHRANE, ON, P0L-1C0

LTC Home / Foyer de SLD : VILLA MINTO
241 EIGHTH STREET, P.O. BOX 280, COCHRANE, ON, P0L-1C0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Paul Chatelain

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

To THE LADY MINTO HOSPITAL AT COCHRANE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall develop and implement policies and procedures to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and their bed system was evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

Inspector #627 observed resident #001 on August 10, 2016, to have two top rails engaged in the guard position during stage one of the inspection.

Inspector #627 completed a review of the Minimum Data Set (MDS) assessment upon admission which documented that resident #001 used bed rails for bed mobility or transfer.

A review of the care plan by Inspector #627 documented the use of restraints as a focus that required resident #001 to have two quarter rails on bed used as a PASD (Personal Assistance Services Device).

During an interview with Inspector #627, RN #102 stated that if the resident was admitted from another facility, and the facility had used bed rails, then the bed rails were continued to be used. As well, it depended on resident and family's preference. RN #102 further stated that when bed rails are used the resident is not assessed for the use of bed rails.

During an interview with Inspector #612, the Program Lead for Maintenance and Electrician #103 stated they confirmed that they did not assess residents for bed rail usage, they only assessed the bed system. (612)

2. Resident #005 and #006 triggered from stage one of the Resident Quality Inspection (RQI) related to bed rail use. On August 9, 2016, Inspector #612 observed that resident #005 and Inspector #627 observed that resident #006 both utilized two quarter rails, engaged in the guard position while in bed.

On August 16, 2016, Inspector #627 interviewed DOC #100 who stated they were not aware of any specific resident assessment when bed rails were used. DOC #100 reported that they further verified with the previous DOC (DOC #105), via telephone and the previous DOC (DOC #105), stated that there was currently no specific

resident assessment completed regarding the resident when bed rails were in use.

A memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August 12, 2012 was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes.

This document references the 'Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings' (CGA), as a prevailing practice for the assessing the use of bed rails. The CGA document indicated that automatic use of bed rails may pose unwarranted hazards to resident safety and evaluation is needed to assess the relative risk of using the bed rail compared with not using it for an individual patient.

The use of bed rails should be based on a resident's assessed needs, documented clearly and approved by the interdisciplinary team. Policy considerations included but were not limited to a risk-benefit assessment that identified why other care interventions were not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the resident should be included in the residents' plan of care.

Additionally, a comprehensive assessment and identification of the residents' needs which include comparing the potential for injury or death associated with use or no use of bed rails to the benefits for an individual resident should be included. The CGA identified procedures including individualized resident assessments, sleeping environment assessments, and care planning guidelines. As well, Health Canada recommended that residents be re-assessed for risk of entrapment whenever there is a change in the resident's medication or physical condition.
(627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Oct 31, 2016

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee is hereby ordered to ensure that all residents are protected from abuse by anyone and to ensure that residents are not neglected by the licensee or staff.

The licensee is ordered to ensure:

a) Immediate suspension of staff/team members who have abused/neglected or alleged to have abused and neglected residents pending the results of the investigation.

b) Immediate reporting of any suspected or actual abuse and the information upon which it is based to the Director regarding staff/team members who have abused/neglected or alleged to have abused and neglected residents.

c) Immediate notification of the resident's SDM, if any, and any other persons specified by the resident, upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect that has resulted in a physical injury, pain to the resident or that causes distress to the resident.

Grounds / Motifs :

(A1)
1. 1. The licensee has failed to ensure that residents were protected from abuse and free of neglect by the licensee or staff in the home.

Inspector #627 reviewed a Critical Incident (CI) report that was submitted by the home to the Director on a specific day in 2016, related to an alleged staff to resident abuse. The CI report alleged that PSW #106 caused pain when they provided care to resident #006.

During a resident interview in stage one of the RQI, resident #006 stated that they had been treated roughly by PSW #106 while receiving care on two separate occasions. Resident #006 could not recall the dates.

During a further interview with Inspector #627, resident #006 stated that on two separate occasions PSW #106 had provided care in a rough manner; this had caused them to have pain for a certain number of weeks. The PSW no longer provided care for the resident unless another staff member was present.

The LTCHA Ontario Regulation 79/10 defines "physical abuse" as the use of physical force by anyone other than a resident that causes physical injury or pain.

A review of the home's investigation notes revealed that the home determined that PSW #106 caused pain to resident #006. As a result of the home's investigation PSW #106 was disciplined.

A review of the progress notes in resident #006's electronic chart revealed that RPN #111 had made the previous DOC (DOC #105), aware of the incident via email on a certain day, and that the previous DOC (DOC #105), became aware of the incident the next day but did not report this to the Director until three days after the incident.

A review of the policy titled "Zero Tolerance and Abuse and Neglect #LTC-630, Section F- Dealing with Persons who have abused/neglected or alleged to have abused/neglected", last revised in December 16, 2015, required staff/team member (s) to be immediately suspended pending the results of the investigation.

A review of the "Long Term Care Payroll Sign In Sheet" for a particular day, recorded that PSW #106 worked a certain shift.

A review of the Point of Care Audit, for resident #006, on that particular day, indicated that PSW #106 charted that they provided a wide range of assistance to the resident related to activities of daily living.

The Inspector requested and reviewed the dates that PSW #106 was on paid leave pending the CI investigation.

During an interview with the Inspector, DOC #100 stated that it was the home's policy to suspend with pay, all employees accused of abuse pending the results of the investigation. DOC #100 confirmed that PSW #106 had worked and had provided care to resident #006 on a particular day, during the time of the investigation.

2. A review of PSW #106's personnel file by Inspector #627 revealed a letter dated in a specific month in 2016, sent to PSW #106 by the previous DOC, (DOC #105), which stated that the PSW was reported by a co worker to have been rough when they provided care to resident #006 when they were admitted. The previous DOC, (DOC #105), documented in the letter that they cautioned the PSW that there was a fine line between being rough with residents and physical abuse.

DOC #100 provided the Inspector with an email sent to them from the previous DOC, (DOC #105) dated August 12, 2016, which documented that the initial incident was investigated immediately and it was determined the outcome was not abuse and no CIS report was sent to the Director. The previous DOC, (DOC #105), noted that since it happened again, in a particular month, the CIS was completed at that time and PSW #106 received disciplinary action.

During an interview with the Inspector, DOC #100 confirmed that the incident that was reported in a specific month, was not reported to the Director.

3. Inspector #627 conducted a record review for resident #006's records to identify any additional incidents of reported concerns between the resident and PSW #106. Inspector #627 interviewed RPN #112 by telephone who stated that on a specific day in 2015, they had been told by resident #006's substitute decision maker (SDM) that the resident reported to them that PSW #106 was rough giving care. Also, PSW #106 refused at times to assist the resident with a particular activity of daily living as per the plan of care and would not let the resident do their activities of daily living for themselves, as this took too much time and PSW #106 had removed an item from

the resident's room which the resident wanted to keep.

The Inspector reviewed an email provided by RPN #112 which the RPN sent to the previous DOC, (DOC #105), on that specific day in 2015. The email documented that both resident #006 and the resident's SDM voiced concerns about PSW #106's interaction with resident #006 and that the resident was upset because PSW #106 took a specific item away. The email also documented that resident #006's SDM stated that resident #006 was scared to ask for anything because they were made to feel a certain way. As well, when PSW #106 attempted to assist the resident with a particular activity of daily living, the resident felt afraid of a particular outcome.

A review of resident's #006's progress notes dated four days after the specific day in 2015, detailed the conversation the previous DOC, (DOC #105), had with resident #006's SDM. The progress note was regarding the incident on the specific day in 2015.

On August 18, 2016, during a telephone interview with the Inspector, the previous DOC, (DOC #105), stated that they had investigated the incident that occurred on a specific day in 2015 and documented in Point Click Care (PCC). The previous DOC, (DOC #105), confirmed that the incident had not been reported to the Director. (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Oct 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 20 day of September 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARIE LAFRAMBOISE - (A1)

Service Area Office /
Bureau régional de services : Sudbury